Before the Federal Communications Commission
Washington, DC 20554

In the Matter of:
Rural Health Service Support Mechanism **CC Docket No. 02-6**

EX PARTE COMMENTS SUBMITTED BY THE
STATE OF ARKANSAS RURAL HEALTH WORK GROUP
IN RESPONSE TO THE
NOTICE OF PROPOSED RULEMAKING & ORDER
RELEASED April 19, 2002

I. Introduction

The State of Arkansas Rural Health Workgroup (ARHWG) respectfully submits its reply comments in the above referenced proceeding. The ARHWG is a working group representing public officials responsible for rural hospitals in the State of Arkansas. The Arkansas Rural Health Workgroup (ARHWG) works on behalf of rural health care providers and other state agencies that serve to increase connectivity to medical information in rural communities.

The ARHWG includes representatives from the following Arkansas entities: University of Arkansas Medical Science, Department of Information Systems, Arkansas Department of Health, Arkansas State legislators, Governor's Office, Office of Executive CIO, and the Arkansas Hospital Association, Community Health Centers of Arkansas, INC. These individuals have offered ongoing support for rural health care providers and consortia to navigate the Rural Health program's application process from the beginning, through multiple steps, and finally, to the acquisition of reimbursements on their telecommunications and advanced services purchases. The ARHWG members have knowledge about the Rural Health program because they file Rural Health applications, are responsible for state network, and regularly work with the Universal Service Administrative Company's Rural Health Division ("Administrator"), and have a particularly good grasp of the program's history and intent. These comments reflect the best knowledge available about the Rural Health program and were developed with the principles that support the Telecommunications Act of 1996.

The ARHWG shares the concern that the FCC has regarding the lack of participation in the rural health care universal service program. We believe the core of the problem lies in the current funding schema which relies on a comparison of Urban rates to Rural rates for establishing participation. We address this issue in the body of this submittal.

In this Notice of Proposed Rulemaking and Order (NPRM), the Commission has requested comments on specific issues and the general program administration so that the Commission and the Administrator can fine-tune the program in ways that improve operation, ensure equitable distribution of program funds, and prevent fraud, waste and abuse. We appreciate the opportunity to comment on these important issues and strive to provide the perspective of the state organizations we represent and the rural health care providers we serve.

Streamlining the program by making the application process easier will ensure that rural health care providers in need of service are able to apply for funding. In the state of Arkansas there are 45 RHCPs. Of these an average of 26 rural health care providers have received funding. This means there are 43% rural health care providers that have not received Rural Health funding during the first five (5) years of the program. Any number of factors could be the reason for non-funding: program complexity and return on investment of time are just a few.

The ARHWG agrees that certain changes to the rules affecting the rural health care support mechanism could significantly bolster the availability of telemedicine and telehealth, thereby enhancing critical

diagnosis and communication support for isolated health centers throughout the rural United States in the event of a national public health emergency. It is our recommendation that funding for Rural Health Care Providers be applied as a discount on telecommunications services as opposed to the urban/rural difference. We recommend the Rural Health Program mirror the Schools & Libraries Program in applying discount-based funding based on poverty level within a RHCP's serving area. We do not recommend the expansion of the Rural Health Care Program to include equipment. The funding of on-going connectivity charges to other health care providers to share information is vital to RHCPs, especially as they prepare for bio-terrorism. With changes as mentioned throughout this document, the impact and use of program dollars will be increased.

Comments

Members of the ARHWG offer to participate in a task force developed by the FCC and/or the Rural Health Division to address implementation of these new rules.

ELIGIBLE ENTITIES

1. **We seek comment on whether we can and should interpret the statute to enable such clinics and emergency service providers to receive discounted services supported under the rural health care mechanism. The number and importance of clinics with these or similar arrangements may be becoming – or may have already become -- a critical part of the health care network in rural America.**

   We would like the Commission to consider the expansion of the definition of an eligible health care provider to include any rural, not-for-profit health care entity with a certified Medicare and/or Medicaid provider number. Expanding the definition as suggested would mean the Universal Service support mechanism will be more widely used and meet its potential.

   For purposes of simplicity, we respectfully ask the Commission to define rural areas as any area not designated as a metropolitan statistical area (MSA) and include any area falling under the Goldsmith Modification with an MSA.

   The Commission should also consider amending the eligible provider list to include for-profit hospitals. In many rural communities, a for-profit entity may be the ONLY provider of healthcare services. Absent of discounted telecommunications services, rural citizens in that community would not have access to the benefits of telehealth, as per the intent of Congress, if the cost of establishing connectivity to telemedicine networks is prohibitive, as is often the case.

   We suggest that Universal Service Fund discounts also be applied to ANY for-profit hospital when that hospital is:

   a) The ONLY hospital in a rural county; and/or
   b) That hospital provides services to Medicare and Medicaid patients at a level of more than 50% of their gross revenues accrued in services to these patients. It could be argued that these hospitals are public in character by virtue of the beneficiaries they serve.

   Both of these issues are important in Arkansas. There are nine (9) areas in Arkansas where the only hospital in the rural county is for-profit. All hospitals in Arkansas meet the criteria listed in item B.

2. **We also seek comment on how the rural health care mechanism would benefit entities that function both as covered health care providers and as entities that do not fall under section 254(b) (7) (B). In particular, we seek comment on whether it would be both practicable and consistent with the statute to prorate discounts. Such prorating could**

ensure that the rural health care universal service support mechanism benefits such entities only to the extent that they operate as covered health care providers.

Changes in eligibility of both services and entities will increase the demand on available funds. At some point it is conceivable the demand will exceed the Rural Health Program's ability to commit 100% of the funds requested by an applicant. When this occurs it will be necessary to determine who receives funding, and whether they receive the full amount of their request. Implementation of a priority of funding matrix would be necessary at this point. The priority could be based on any number of criteria; number of RHCPs in an area, population served by the RHCP, and poverty level in the serving area are just a few criteria on which the priority could all be based. Members of the ARHWG are willing to participate in a task force to assist the FCC and Rural Health Division in setting criteria for priority. If the program's funding were based on a poverty level and applied as a discount on services similar to the Schools and Libraries Program, the priority level would be set.

3. **We seek comment on whether we should adopt any additional measures to effectuate the statutory restriction in cases where a health care provider engages in both the provision of health care services and other activities. We therefore seek comment on how best to avoid waste and fraud, specifically in situations where entities perform a significant amount of non-health related activities.**

INTERNET

4. **We seek comment on whether we should eliminate support for toll charges to ISPs and instead provide support for any form of Internet access provided to rural health care providers.**

Although there is a proliferation of ISPs, some RHCPs may still have to access the Internet via a toll call. We recommend that the support for toll charges to ISPs remain intact.

5. **We seek comment on the range of health care services and information that are available via the Internet, on the ability of the Internet to provide to rural communities the type of health care information that is available in urban areas, and, in general, on how health care providers can make use of the Internet to provide better health- related services. In light of these changes, the provision of support for Internet access could be beneficial in achieving the goal of section 254. We therefore seek comment on whether the rural health care support mechanism should now include discounts on Internet access, whether provided on a dial- up or high- speed broadband basis, and whether such support would be economically reasonable and technically feasible.**

We concur that discounts should be provided to support any form of Internet access provided to rural health care providers.

We concur that discounts should be provided to underwrite access to Internet connectivity via any modality, to include "no-telecommunications service providers." In some communities, other providers of telecommunications technology such as the local cable operator or public utility board have chosen to invest in infrastructure so as to provide broadband access the to Internet. We believe that healthcare providers who choose to access those services should be eligible for discounts if that the telecommunications technology provides quality of service that supports its use for medical purposes.

We also believe that these discounts should be based on comparison of bandwidth rather than specific technologies as the choices available for rural communities are generally more limited than those in urban areas. We believe that modifications of these rules will support greater

investment in broadband telecommunications infrastructure in our rural communities by existing providers of current and emerging technologies.

In some states the benefits of funding Internet may still not be realized unless funding is based on a discount instead of the rural/urban difference.

6. **We seek comment on whether demand for Internet access is likely to reach the $400 million cap on the amount of support to be provided by the rural health care mechanism, and how increased demand would affect the operation of the 44 See Universal Service Order, 12 FCC Rcd at 9107, 9158, paras. 630, 744. 12 Federal Communications Commission FCC 02- 122 13 rural health care mechanism.**

   In general, we seek comment on the positive or negative effects that a decision to support Internet access will have on the rural health care support mechanism, from the perspective of the health care providers, the service providers, and the Administrator. In addition, we seek comment on how such implementation could be effectuated in keeping with the Commission's long standing universal service principles, specifically competitive neutrality and technological neutrality.

COMPARISON OF RATES – URBAN/RURAL- FUNCTIONALITY

7. **We seek comment on whether the "similarity" of urban and rural services should be determined on the basis of functionality from the perspective of the end-user, rather than on the basis of whether urban and rural services are technically similar. We also seek comment on whether, for purposes of determining the urban rate, the Administrator should allow comparison of rates in any urban area in the state, not just comparison with the rates in the nearest city with a population of over 50,000. In addition, we seek comment on whether to eliminate the MAD restriction, and seek comment on other alternatives. Furthermore, we seek comment on certain changes relating to the calculation of the urban rate in insular areas.**

   The ARWG believes the services should be based on functionality from the perspective of the end-user, rather than on the basis of whether the urban and rural services are technically similar. The end user does not always understand the technical nuances between services. The end user is only aware of the results. The ARWG believes the funding of services should be a discount based on the poverty level within the RHCP's serving area similar to the Schools and Libraries E-rate Program. If the funding continues to be based on a comparison of rates in an urban area, the comparison must be of rates in any urban area in the state.

8. **We seek comment on changing our policy of comparing urban and rural rates for particular telecommunications services, such that the discounts would be calculated by comparing services based on functionality of the service from the perspective of the end user. In particular, we seek comment on whether comparisons should be made between or among different types of high- speed transport offered by telecommunications carriers that may be viewed as functionally equivalent by end- users. We also seek comment on whether this proposed policy change would better effectuate the statutory goals of section 254.**

   The ARWG believes discounts should be based on comparisons of bandwidth rather than specific technologies as the choices available for rural communities are generally more limited than are those in urban areas. We believe modifications in these rules will support greater investment in broadband telecommunications infrastructure in our rural communities by existing providers of current and emerging technologies.

9. We seek comment on the fairest and most effective way to compare functionality between or among different types of telecommunications services. We seek comment on how a functionality- based approach would affect discounts for all telecommunications services, including fractional T- 1 lines, ISDN, Frame Relay services, and ATM services, and any other such telecommunications services for which the rural health care universal service support mechanism may offer discounts. We also seek comment on how this possible modification would affect health care providers seeking discounts for satellite services.

10. We further seek comment on whether, and how, a functionality approach could be implemented consistent with current requirements concerning the Maximum Allowable Distance. 61 If the MAD requirement is altered or eliminated as discussed in paragraphs 45- 48 below, we seek comment on how that change may interrelate with any proposed treatment of satellite services. 2. Urban Area 41. Section 254(h)(1)(A) of the Act directs us to provide support for "rates that are reasonably comparable to rates charged for similar services in urban areas in that State." 62 Under our rules, as described above, the urban rate is based on the rate for similar services in the "nearest large city," defined as "the city located in the eligible health care provider's state, with a population of at least 50,000, that is nearest to the healthcare provider's location, measuring point to point, from the health care provider's location to the point on that city's jurisdictional boundary closest to the health care provider's location. 63 In the Universal Service Order, the Commission chose to base the urban rate on the rate in the nearest city of at least 50,000 in the belief that such cities "are large enough that telecommunications rates based on costs would likely reflect the economies of scale and scope that can reduce such rates in densely populated urban areas." We seek comment on whether to alter our rules to allow comparison with rates in any city in a state.

APPLICATION PROCESS

11. We seek comment on ways to streamline the application process to make it more accessible to rural health care providers.

Rebates are not received in a timely manner due to delays in the administration of the funding mechanism and in a telecommunications company's response to completing the necessary RHCD forms. The RHCP is fronting the cost of the eligible service and receives a rebate only after the telecommunications company files the appropriate RHCD forms. This creates a problem when the rebates arrive after the fiscal year end in which the RHCP had the expense. This creates major accounting problems for individuals whose yearly funding comes from federal grant sources and for others who must also develop accurate fiscal year budgets.

Our recommendations to deal with this issue include the following:

1. Telecommunications companies would have a maximum of 90 days to complete and finalize all the forms with the RHCD.
2. During that 90-day period, the telecommunications carrier may bill the customer for all applicable charges.
3. After the 90-day period, the telecommunication carrier may only bill the customer for the discounted amount and must rebate the difference for the first 90 days of service, within 45 days of completion of the RHCD forms.
4. If the telecommunications carrier fails to respond in 90 days, they must continue the telecommunications service and refrain from billing the customer until the forms have been finalized.

12. We also seek comment on ways to ensure that rural health care providers are apprised of changes in deadlines for application filings and other material changes in the application and appeals process.

ALLOCATION OF FUNDS

13. We seek comment on whether to modify our current rules governing the allocation of funds under the rural health care universal service support mechanism if demand exceeds the annual cap.

COMPETITIVE BIDDING

14. We seek comment on the effectiveness of the rural health care universal service support mechanism's competitive bidding rules.

15. We seek comment on whether the requirement can and should be waived in certain circumstances (e. g., when applications are submitted by small entities), whether such a change is necessary or prudent, and how we may implement it with minimal administrative effort and expense, while fulfilling our obligations to reduce waste, fraud, and abuse and ensuring that universal service support is used "wisely and efficiently.

16. We seek comment on whether there currently are adequate measures to ensure that rural health care providers buy the most cost- effective services.

17. we seek comment on whether we should implement changes to encourage applicants to use lowest cost technology available, regardless of whether that technology involves wire line, coaxial cable, fiber, terrestrial wireless, satellite, or some other technology. If so, we seek comment on how those changes should be implemented. c. Encouraging Partnerships with Clinics at Schools and Libraries.

POOLING OF RESOURCES

18. We seek comment on ways in which the rules or policies of the rural health care universal service support mechanism might be altered to better encourage rural health providers to pool resources with other entities in order to limit costs for themselves and thereby utilize support more efficiently.

AUDITS-WASTE, FRAUD, ABUSE

19. We seek comment on the effectiveness of our current rules regarding audits, and other procedures to ensure the appropriate use of funds available under the rural health care universal service support mechanism.

20. We further seek comment on any other rules that would help to combat potential waste, fraud, and abuse with respect to the rural health care universal service support mechanism.

ADOPTION OF NEW RULES

21. We seek additional comments on whether we should adopt additional rule changes, consistent with the statute, to improve our rules and policies regarding the rural health care universal service support mechanism.

In the state of Arkansas the primary telecommunications carrier, Southwestern Bell (SBC), has been proactive in assisting rural areas in the state. In 1992 SBC restructured their rates so there was no Urban/Rural difference. This is true in many states such as Mississippi, Missouri, and Louisiana. Because the telecommunications carrier in these states has been proactive, the support mechanism used by Rural Health does not and will not meet to its potential.

We recommend the Commission consider changing the current support mechanism in favor of a support mechanism based on economic need in the community. The E-rate program bases the eligible entities discount on the local school districts Free and Reduced Lunch (FRL). The FRL is used by several programs to determine level of economic need in the community. If the FRL is an acceptable means of calculating economic need for schools and libraries, it is also an acceptable means of calculating economic need for a rural health care provider.

22. We seek comments on various alternatives to enhance our existing rural health care universal service support mechanism.

The ARHWG believes the primary element causing the lack of participation in the program is that the funding is based on the difference in cost of services in an urban versus rural area. As stated earlier in this document, the RHCPs located in those states that have postalized rates do not benefit from the program. The funding these participants would receive is such that it rarely covers the administrative costs involved in preparing and submitting necessary paperwork. **The funding they receive is so small many of them have decided it is not worth the effort to file. The ARHWG believes the program's potential would be realized if the funding mechanism were based on a serving areas poverty level or need and not an Urban/Rural difference. The E-rate Program for Schools and Libraries use of Free and Reduced Lunch figures in relation to the MSA is a good example.**

There has been a lot of press concerning waste fraud and abuse in the Schools and Libraries Program. This has typically occurred in the Priority II category, Internal Connections. There has been little to no abuse found in the telecommunications category. By limiting the Rural Health Funding to telecommunications connectivity and Internet access, the ARHWG feels the program will not face the waste, fraud and abuse issues their sister program has suffered.

The ARHWG believes the program's potential would be best realized if a second funding methodology was establish that allowed program participation based on a serving area's poverty level or need rather than Urban/Rural cost differences. The ARHWG suggests that this second funding methodology be based on the existing, well-established funding methodology used by the E-rate program which is based on a community school's participation in the Federal Free and Reduced Lunch Program. We believe this second funding methodology be in addition to – not in lieu of – the existing difference-based funding and the decision be left to each state as to which method they use.

Respectfully Submitted:

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